Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the matter of	)	
	)	WC Docket No. 02-60
Rural Health Care Support Mechanism	)	

COMMENTS OF RURAL NEBRASKA HEALTHCARE NETWORK, INC.

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SUMMARY

Rural Nebraska Healthcare Network strongly supports the Commission's proposals to reform the Rural Health Care Support Mechanism by implementing a new Health Infrastructure Program to deploy new and upgraded broadband infrastructure, and a Health Broadband Services Program to support the monthly recurring costs of advanced broadband services to the public and non-profit rural health care providers. The National Broadband Plan correctly recognized the critical need to deploy advanced broadband infrastructure, with enhanced point-to-point connectivity and greater bandwidth, redundancy and reliability, for telehealth and telemedicine applications, and the Commission's proposals are a major step in closing the connectivity gap faced by rural health care providers.

It is essential, however, that these promising new programs are structured in ways that will maximize participation by rural health care providers, rather than to undermine such participation, as has too often been the case with unrealistic and burdensome rules. It is also essential that the Commission keep in mind two very important characteristics of health care providers: 1) they are not familiar with broadband networks and therefore require outside assistance and, as a general matter, 2) they do not have deep pockets. With these thoughts in mind, RNHN comments that the Commission should:

- encourage, not exclude, participation by for-profit entities because without such public/private partnerships, it is unlikely that the goals of the National Broadband Plan will be realized;
- allow health care providers to raise matching funds and to cover operating costs with revenues received for excess capacity priced on the basis of incremental costs;

- recognize that broadband projects, such as those proposed under the Healthcare Infrastructure Program, require substantial administrative and legal support which are as integral to projects as are the costs of the network and, as a result, should be eligible for funding;
- streamline the administrative process, such as reducing reporting requirements and frequency, which will reduce the financial burden on health care providers who, for the most part, have limited means, and will increase the speed in which the programs accomplish the ultimate goal;
- not impose caps and limitations, *e.g.*, project funding, total number of funded projects and minimum bandwidth, because they discourage participation and inhibit, if not prevent, need-based projects;
- base funding priorities on factors other than HPSA to ensure a correct characterization of participants and their needs; and
- reject meaningful use criteria as a condition of funding.

All of these comments are designed by RNHN with the expectation that they will encourage maximum participation in the new programs and permit rapid deployment of the advanced broadband infrastructure that rural health care providers, such as RNHN, desperately need.

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Rural Nebraska Healthcare Network, Inc ("RNHN"), hereby submits these comments in response to the Rural Health Care Support Mechanism Notice of Proposed Rulemaking ("*Notice*").[1] The *Notice* proposes and seeks comment on reforms to the universal service health care support mechanism that are consistent with the recommendations set forth in the National Broadband Plan[2] to expand the reach and use of broadband connectivity for and by public and non-profit health care providers.

I. INTRODUCTION

RNHN commends the Commission for stepping forward with an innovative approach to assist rural health care providers in gaining access to advanced health care resources. RNHN strongly supports the Commission's proposals to reform and reinvigorate the Rural Health Care Support Mechanism by creating a Health Infrastructure Program ("Infrastructure Program") to deploy new and upgraded broadband infrastructure, and a Health Broadband Services Program ("HBS Program") to support the monthly recurring costs of advanced broadband services to public and non-profit rural health care providers. These programs proposed by the Commission are a step in the right direction. However, some of the Commission's proposals will fail to fix

[1] *In re Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010).

[2] Federal Communications Commission, *Connecting America: The National Broadband Plan* (rel. Mar. 16, 2010), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-296935A1.pdf.

the connectivity gap in rural America and may actually prevent rural health care providers from using the programs.

As explained in more detail below, the Commission should refrain from imposing unduly burdensome and onerous rules that would retard participation in these programs and undermine the core objectives of the National Broadband Plan. Instead, the Commission should craft narrowly tailored and focused requirements so that applications are judged on their merits and not their compliance with rules that have no place in commercial transactions.

II. BACKGROUND OF RNHN

RNHN is a consortium of nine hospitals and twenty supporting clinics in the Panhandle of Nebraska that have worked together strategically since 1996 to develop sustainable local health and preventative health services.[3]

RNHN enables the participating hospitals and clinics to plan and implement improvements to their systems of care, to develop and provide training opportunities, to plan for trauma and emergency preparedness, and to address policy issues impacting health care. RNHN has been successful in sharing resources and overcoming many of the barriers rural health care providers face today. In one of its major initiatives, RNHN is currently in the planning and implementation phase of joining the Nebraska Electronic Health Information Initiative, the state designated health information exchange, which will enhance patient safety and quality of care through the effective exchange of health records and information among health care providers.

Additionally, RNHN has established a Training Academy with the Western Nebraska Community College to provide ongoing education efforts for its clinicians and staff. In addition to the specific health information and IT user training courses, the Training Academy is

[3] RNHN consists nine hospitals, eight of which are Critical Access Hospitals. A Critical Access Hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures.

developing and purchasing courses which can be offered through video conferencing and webinars. These courses, which enhance the health care system and credentials of health care employees, range from direct skills such as Phlebotomy to Hospital Incident Command for emergency response. Meanwhile, an ambitious project of health information training has been ongoing since 2004 with more national certifications per capita in western Nebraska than anywhere else in the country.[4]

The participating hospitals of RNHN provide crucial access to their services through 55 primary care physicians (36 general practice or family practitioners, 11 internal medicine, 3 pediatricians, 5 obstetricians/gynecologists). Six psychiatrists also practice in the region. Additionally, the hospitals provide rural health clinics, which most patients view as direct extensions of the hospitals. Two of these clinics are provider-based, seven are hospital-based, and a federally qualified health clinic primarily serves Scottsbluff County. All of the clinics serve the uninsured.

The number of services available at each RNHN facility varies, but as a general matter, access to specialized care is quite limited. For instance, at Kimball Health Services, a 20-bed hospital 65 miles east of Cheyenne, Wyoming, medical care is available for those seeking emergency treatment, blood bank, immunizations, lab results, radiology, and nutrition. However, Kimball clinicians must rely on other hospitals for other areas of expertise or functionality (*e.g.*, radiology and other tests that need to be sent to Regional West Medical Center). Kimball does not have the ability to provide many other services, including prenatal care, cancer treatment, diabetic treatment, intensive care, occupational health, pediatrics,

[4] Sixty-seven staff-persons have participated in trainings to become a Certified Professional Health Information Technology or Certified Professional in Electronic Health Records.

physical therapy and OB/GYN. For this care, Kimball patients must seek treatment elsewhere—with the accompanying commitments of time, money, and effort.[5]

Likewise, Box Butte General Hospital ("BBGH") in Alliance, Nebraska, is the initial point-of-care for many rural Nebraskans seeking medical service. Although BBGH has some limited resources to provide services like OB/GYN, prenatal, radiology, pediatrics and orthopedics, those in need may be referred to Scottsbluff, Fort Collins, Rapid City, South Dakota, or Denver, Colorado to receive high-level or specialized care.[6]

RNHN prides itself on its proven track record as a leader in implementing rural health telemedicine. In 2005, RNHN was awarded Outstanding Organization of the Year by the National Rural Health Association. RNHN was the recipient of a grant from the Agency for

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[5] Most Kimball patients are referred to Scottsbluff for such items as occupational health, orthopedics, prenatal care, cancer treatment and OB/GYN. Kimball patients may be referred out of the Nebraska panhandle entirely for cardiac, surgical services, or specialty care (burns, pediatric, ICU).

[6] For BBGH patients, the following scenarios, all of which require significant travel and administrative coordination, are typical:

1) If a patient arrives in the ER with fractured hip, x-rays are taken by an x-ray technician at the hospital. The x-ray is then sent electronically to Radiology Imaging Associates in Denver, Colorado. The x-ray is read by a radiologist and a result may take up to 2 hours. The radiologist then communicates the results verbally to the patient's provider. If the fracture is severe enough to require surgery, the patient must be transferred to Scottsbluff via ambulance 60 miles away. In this case, the patient is stabilized and the local ambulance service is contacted for a transfer. Usually the local ambulance service will transfer the patient, but occasionally it may be necessary to contact another ambulance service to make the transfer. After surgery the patient can be transferred back to BBGH.

2) A patient may arrive at the ER with a complaint of chest pain. Lab tests and an EKG will be ordered. If the tests come back positive of, for instance, a heart attack, the patient will be transferred to either Rapid City, South Dakota or Fort Collins, Colorado. Rapid City is approximately 155 miles one way from BBGH and Fort Collins is approximately 205 miles. Typically, an air ambulance service is contacted to transport the patient, but if the patient is unable to fly, a ground ambulance crew will be contacted for the transfer. The patient is stabilized and then transferred to a higher level of care. Usually, the patient will be referred back to BBGH for cardiac rehabilitation. The patient may be able to visit with a cardiologist at BBGH, but occasionally it may be necessary to travel elsewhere for follow-up care.

3) A patient may visit the local primary care provider for a questionable mole. Typically, the patient is referred to a dermatologist, either in Rapid City or Cheyenne, Wyoming (approximately 160 miles one way). The patient will be required to travel to visit with the dermatologist for the initial examination but may need to make several follow-up visits if the mole is determined to be cancerous.

Healthcare Research and Quality Planning and Implementation, which has laid the foundation for the health information exchange.[7]

RNHN is also a participant in the Rural Health Care Pilot Program ("Pilot Program") and was awarded support of $19.2 million under that program to design, construct, operate, and maintain a fiber optic network connecting each of its member hospitals with each other and with other health care facilities. In order to meet the 15 percent contribution requirements set forth in the Commission's Order approving RNHN's Pilot Program Application,[8] RNHN plans to build two networks: a 36 fiber dedicated medical network and a 48 fiber commercial network. RNHN will own and operate the medical network, which will be a private, multi-gigabit, lit fiber optic network. A wholly owned subsidiary of RNHN, Middle Mile Broadband, Inc., will own the commercial network and will sell dark fiber IRUs to raise the 15 percent contribution required for the construction of the network and to provide funds for the sustainability of the medical network.

Notwithstanding its history of success, RNHN recognizes the challenges it faces, particularly as its current technological needs and capacity struggle to satisfy growing patient demands. For instance, although the Pilot Program network to be deployed by RNHN will alleviate some of the shortfalls of providing health care in the Panhandle of Nebraska, the requirement that use of the network is limited to public and non-profit health care providers excludes for profit health care providers who are an equally important component of health care. Due to the limitations in services available at each RNHN hospital, the utility and need for the

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[7] The Agency for Healthcare Research and Quality is an agency of the Department of Health and Human Services.

[8] *See In re Rural Health Care Support Mechanism*, Order, 22 FCC Rcd 20360, 20399-400 ¶ 77 (2007) ("*Pilot Program Selection Order*").

Commission's proposed Infrastructure Program and HBS Program becomes all the more apparent.

III. HEALTH INFRASTRUCTURE PROGRAM

A. No Cap Should Be Placed On The Total Funding Amount For Each Project Or On The Total Number Of Projects Funded

The Commission's proposal to place arbitrary caps on the amount funded or the total projects funded under the Infrastructure Program should not be adopted. The Commission reasons that a cap should be placed on the amount an applicant may request because 90 percent of the projects in the Pilot Program had proposed budgets below $15 million. It does not follow, however, that the Infrastructure Program should be capped at that amount or, for that matter, at any amount.

Although setting a per project funding cap may "help ensure that multiple projects across varying unserved geographic areas will be eligible to receive funding for infrastructure," caps will have negative effects that will outweigh this benefit.[9] A per project funding cap will cause applicants to limit projects to meet funding limitations or to not apply at all, which may once again lead to unused funds for rural health care. No one benefits when funds go unused. Moreover, setting a per project cap will deprive adequate funding to an applicant who has nevertheless demonstrated significant need.

Project funding should be based on the project's proposal and justifiable needs and costs, not on any arbitrary cap. If necessary, projects should be prioritized based on such factors as lack of adequate or affordable broadband in the proposed geographic area, the rural or medically underserved area classification of the county(ies) where the project will be deployed, types of

[9] *Notice*, 25 FCC Rcd at 9385 ¶ 30.

health care providers that will utilize the network, and geographic area covered.[10] Additionally, as described in further detail below in Section V, more funds will be available if the Commission does not limit Infrastructure Program funding to $100 million per year.

Placing a cap on the number of projects per year to "allow USAC to devote greater resources and time to ensuring their success" is not the solution to the ill-preparedness of applicants to undertake the complex process of developing a new health care network.[11] The role of guiding applicants through the process of developing a new health care network should be left to industry experts, not to USAC.[12] Accordingly, and as discussed in the following section, the solution is to include program administration, technical consulting and coordination, and legal costs in costs eligible for funding.

B. In Addition To Funding Reasonable Administrative Expenses, The FCC Should Fund Certain Costs Not Directly Related To Access Or To Design, Construction Or Deployment

The Commission has concluded that section 254(h)(2)(A) of the 1996 Act authorizes the Commission to establish mechanisms that "enhance . . . access to advanced telecommunications and information services for all public and non-profit . . . health care providers . . . ."[13] As noted by the Commission, one of the lessons learned from the Pilot Program was that applicants were ill-prepared to undertake the complex process of developing a new health care network, and consequently required ongoing coaching and support to navigate their way through the process.[14]

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[10] *See infra* Section II.B.

[11] *See Notice*, 25 FCC Rcd at 9385 ¶ 31.

[12] It is likely that many Pilot Program participants needed ongoing coaching and support from USAC to navigate their way through the process because they could not afford the necessary industry experts, whose costs were not funded under the Pilot Program. Moreover, many of the problems associated with the Pilot Program were due to the bureaucracy of USAC and the *ad hoc* rules that were imposed to accommodate a program that was not well suited to USAC's funding mechanisms.

[13] 47 U.S.C. § 254(h)(2)(A).

[14] *Notice*, 25 FCC Rcd at 9385 ¶ 30.

The Commission's proposal to exclude costs not directly related to access or design, construction, or deployment is, however, fundamentally at odds with correcting that problem.

Excluding the costs related to program administration, technical consultation and coordination, legal, and personnel costs will perpetuate the problem of ill-preparedness by applicants. Put simply, without incurring these costs, rural health care providers' ability to design, construct, or deploy the advanced broadband infrastructure necessary to meet their needs will be severely hampered and fraught with risks. Rural health care providers simply do not have the in-house expertise necessary to create advanced broadband infrastructure nor do they have funds to hire such expertise.

In keeping with the Commission's focus on only funding costs that enhance access to advanced telecommunications and information services, the Commission should only exclude those costs that do not assist the applicant in enhancing such access. From this point of view, costs such as personnel, travel, legal, program administration, and technical consultation and coordination are all necessary expenses incurred to assist eligible health care providers to deploy and access advanced telecommunications and information services, *i.e.*, to enhance access.[15]

Limitations on funding expenses suffer from the same problems and negative effects suffered by caps on program funding, namely, the inhibition, if not prevention, of worthy applications. The costs eligible for funding should be any costs that can be shown to be reasonable and related to the project.

[15] To some extent, the Commission recognizes this interpretation in its proposal to fund reasonable administrative expenses. For example, the Commission lists negotiating with vendors (which typically involve lawyers) and reviewing bids (which likely need technical expertise) as potential administrative expenses that would be funded. *See Notice*, 25 FCC Rcd at 9386-87 ¶ 37.

C. The Program Should Fund Ongoing Maintenance Costs For The Network And NLR/Internet2 Membership Fees

Because the Commission proposes to require IRU agreements to include maintenance of the fiber/network (not including electronics) for the term of the IRU, the health infrastructure program should fund up to 85 percent of the reasonable, necessary and customary ongoing maintenance costs of the IRU for the life of the IRU. Without such funding, the sustainability of networks funded by the program would be severely diminished. Furthermore, the Commission should require that the terms relating to operations and maintenance of the IRU be separate and distinct from the agreement granting the IRU to ensure that the IRU is viewed as a property right and not a service.[16] Additionally, maintenance agreements should not be subject to competitive bidding rules in the event that the carrier supplying the IRU will maintain the IRU.

While commercial backbones are sufficient for certain Internet uses, there has been a market failure when it comes to advanced broadband applications for medical applications. Commercial networks are not optimized to support advanced broadband applications like telepresence and telemedicine. Moreover, commercial networks do not offer next-generation Internet technologies like IPv6 and IP multicast, which are critical to telepresence and telemedicine. Consequently, RNHN urges the Commission to fund both membership fees or connections to access NLR or Internet2.[17] Funding NLR and/or Internet2 membership fees or connections to their networks should result in lower access and usage fees and will also provide

[16] If the operations and maintenance of an IRU is included in the IRU Agreement, the IRU could be considered a service. If so, the seller of the IRU could reject the agreement as an executory contract if it declares bankruptcy. As such, a project participant could be divested of its right to the IRU. *See* Charles A. Rohe & Richard H. Agins, *Indefeasible Rights of Use in a Revived Telecommunications Industry: Revisiting the Treatment of IRUs in Bankruptcy Proceedings*, 2008 NORTON ANN. SURV. OF BANKR. L. 333 (2008).

[17] The *Notice* is not clear on whether the Commission proposes to fund NLR and/or Internet2 membership fees or to fund connections to such networks, or both. For purposes of these comments, RNHN argues for and assumes both. *See Notice*, 25 FCC Rcd at 9388 ¶ 40.

rural health care providers with access to a myriad of other health care providers, including research institutions that will help deliver cutting edge care and transform rural health care.

D. For Profit Entities Should Not Be Excluded As An Eligible Source For The 15 Percent Contribution Requirement

The Commission's proposal to exclude any for-profit entity as an eligible source for the 15 percent contribution should not be adopted. The Commission acknowledges that it "ha[s] learned from [its] experience with the Pilot Program that some applicants have difficulty even meeting a 15 percent contribution requirement" and that "it is difficult for rural health care providers to secure funds to invest in broadband infrastructure, given the competing demands for limited resources in rural areas."[18] Yet the Commission proposes to restrict access to much needed capital to build the infrastructure.

The development of a state-of-the-art broadband infrastructure solely by the public sector has not proven to be an effective or efficient method of bringing broadband services to rural America.[19] Public/private partnerships, on the other hand, offer an attractive means by which to serve rural areas that are generally more expensive to serve. As the National Broadband Plan states: "It is in a community's best interest when public, non-profit and private institutions share infrastructure costs and bring broadband to more of the community. The [Commission] should define, early in the process, permissible ways in which excess capacity can be deployed and allocated to non-USF-eligible institutions."[20] In keeping with the recommendations of the National Broadband Plan, which encourages "the partnership of the public and private sectors in

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[18] *Notice*, 25 FCC Rcd at 9391 ¶ 45, n.91.

[19] It would be very difficult for rural health care providers to deploy an advanced broadband network now, especially considering that states are strapped for cash in the current economy.

[20] *National Broadband Plan*, at 216.

the continued growth of broadband services and information technology,"[21] the Commission should allow applicants to fulfill their share of the funding commitment through appropriate in-kind contributions and/or private sources, subject to adequate safeguards and monitoring.[22]

Additionally, ninety days after project selection is too short a time for applicants to demonstrate that they have a reasonable and viable source for the contribution requirement. Again, the lessons of the Pilot Program should guide the Commission on this proposal. There, the Wireline Bureau found it necessary to extend the Pilot Program for at least a year because at the time only a third of the 69 Pilot Program projects had received funding commitments.[23] The Bureau found that "[d]ue to the economic downturn, some participants have . . . experienced difficulty in raising funds not covered by the Pilot Program, including the 15 percent funding match requirement," and that this difficulty is "endangering the success of their projects."[24] Almost three years had transpired by the time of this finding.

E. Participants Should Be Allowed To Transfer Ownership of Funded Infrastructure to Subsidiaries or Affiliates

RNHN strongly agrees with the Commission's proposal to adopt rules that allow for the transfer of ownership of funded projects to subsidiaries or affiliates of the original applicants. If the Commission allows applicants under the Infrastructure Program to build excess capacity or facilities for use by ineligible entities in order to raise funds for the 15 percent contribution and sustainability of the dedicated health care network, health care providers can focus on the

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[21] *National Broadband Plan*, at 182.

[22] Such an approach was adopted by National Telecommunications and Information Administration ("NTIA") regarding Broadband Technologies Opportunities Program ("BTOP") awards. On that basis, no difference exists between the Infrastructure Program and BTOP. They both seek to construct broadband networks. In fact, some BTOP awards were by and for health care providers.

[23] *In re Rural Health Care Support Mechanism*, Order, 25 FCC Rcd 1423, 1426-27 ¶ 6 (2010) ("*Pilot Program Extension Order*").

[24] *Id.* at 1426 ¶ 5.

delivery of health care and not the operations and maintenance of a network. Moreover, the ability to transfer ownership of funded projects to subsidiaries or affiliates is vitally important so that the tax-exempt status of the applicant is not jeopardized in the event the revenues from the project are considered unrelated to the non-profit tax exemption of a participant.

F. The Commission Should Permit And Encourage Applicants To Include Excess Facilities Or Capacity In Their Plans

1. Shared Use Of Excess Capacity Or Facilities Will Benefit Rural Health Care Providers And The Surrounding Communities

Limiting an applicant's ability to build excess capacity or facilities or limit sharing of such capacity or facilities is simply nonsensical and would be an inefficient use of scarce resources. While adoption of advanced broadband services by rural health care is an important goal, the Commission should keep its eyes on the prize of bringing broadband to every American. If broadband is unavailable or insufficient for health care providers, such infrastructure is likely to be unavailable to other entities. As the National Broadband Plan notes, "for-profit eligibility restrictions exclude more than 70% of the 38,000 health care providers; many face the same disadvantages in securing broadband as the eligible providers."[25] Accordingly, the National Broadband Plan recommends that "[s]tatutory restrictions that limit support to public and non-profit entities and program rules that limit support to rural entities should be reexamined" so that "[m]any deserving health care providers, such as urban health clinics and for-profit physician offices that function as the safety net for the country's care delivery system, [will be] eligible for funding under the program."[26]

The Commission, however, can act now without statutory reform by not placing any limitations on the use of the excess capacity or facilities. Infrastructure Program participants

[25] *National Broadband Plan*, at 214.

[26] *Id.*

should be allowed to use excess capacity or facilities for any lawful purpose provided that revenues from such activities are used to sustain the network. Income from use of excess capacity can be used to fund any matching requirement, *e.g.*, 15 percent, and for the sustainability of a network. This policy will lessen the burden on the Rural Health Care Support Mechanism and therefore allow more projects and greater project funding. In short, it makes sense to allow participants to build in excess capacity or facilities for community and other uses.

2. Excess Capacity Should Be Priced At Incremental Cost And It Is Not Necessary To Physically Separate Program Capacity From Excess Capacity

In keeping with the goal of bringing broadband to every American, any excess capacity or facilities should be allowed to be shared with any type of entity at incremental costs. Fully distributed cost models should not be used to price excess capacity or facilities because there are no universally accepted models that are not arbitrary and subjective. Incremental or marginal costs models are acceptable methodologies that are easy to understand and allow for cost control, better planning and the isolation of direct or variable costs. Thus, ineligible users should bear the incremental costs for the use of the network incurred by such users.

It also is not necessary to require excess capacity to be physically separated from the capacity used for the dedicated health care network because excess capacity can be readily identified and such a requirement would unnecessarily increase the cost of the network. For example, RNHN determined that the incremental cost of adding excess fiber within the same cable was approximately $1.4 million; however, if a physically separated cable was constructed, the incremental cost would have been approximately $2.7 million.

G. Any Required Reports Should Be Submitted Annually

Quarterly reporting is unnecessary, especially during project construction. Reporting should be done annually and on an as needed basis, such as when certain project milestones have

been started or completed. Quarterly reporting requirements place a burden on rural health care providers because such providers have limited staff that would need to be re-tasked to complete reports.

H. Competitive Bidding Rules Should Allow For Flexibility In Choosing Vendors

Participants should be allowed to forego competitive bidding as long as the applicant provides a good and sufficient basis for the vendor selection, including a justification for not utilizing competitive bidding. Such a method was allowed under BTOP and should work equally as well with this program.[27]

IV. HEALTH BROADBAND SERVICES PROGRAM

A. The FCC Should Subsidize Any Connections Utilized For The Provision of Health Care

Congress has expressly stated that advanced non-telecommunications services may be eligible for support. Section 254(c)(3) of the 1996 Act authorizes the Commission to "designate additional [special] services" as eligible for support under section 254(h)'s authorization.[28] While section 254(h)(1)(A) is explicitly limited to telecommunications services, section 254(h)(2)(A) expressly directs the Commission to enhance access to such advanced telecommunications and *information services* "for all . . . health care providers . . . ."[29]

As the Commission explained in the *Pilot Program Order*: "In section 254(h)(2)(A), Congress directed the Commission to 'establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications

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[27] *See, e.g.*, NTIA Broadband Technology Opportunities Program (BTOP) Round 2 Guidance, at 67, *available at* http://www2.ntia.doc.gov/files/BTOP_NOFA2GrantGuidance_100319.pdf.

[28] 47 U.S.C. § 254(c)(3).

[29] 47 U.S.C. § 254(h)(2)(A).

and information services for . . . health care providers.'"[30] In addition, section 254(a)(1) and (a)(2) mandate that the Commission define the "*services* that are supported by Federal universal service support mechanisms" but does not limit support to telecommunications services.[31] The use of the broader term "services" in section 254(a) provides further validation for the inclusion of non-telecommunications services in addition to telecommunications services in sections 254(h)(2)(A).

Point-to-point connections, for instance, that enable rural health care providers to post their own data, interact with stored data, generate new data, or communicate over private dedicated networks or the public Internet for the provision of health care are classified as information services and should therefore qualify under the HBS Program. Furthermore, if adoption of advanced broadband services is the goal, there is no basis under section 254 to exclude dark fiber or lit fiber services, or to exclude the reasonable and customary charges to install any advanced broadband service. Fiber solutions are the most cost effective facilities to provide the bandwidth needed by health information technology applications now and in the future. With fiber solutions, instead of building new networks to handle future bandwidth requirements, greater amounts of data can be transferred on existing fiber networks by upgrading networking technology. For example, wave division multiplexing ("WDM") technology, such as course WDM and dense WDM, allows users to place and send multiple signals along a single fiber at the same time. This turns a single fiber into the equivalent of a multiple fibers. Advanced DWDM systems are now being deployed that can transmit at speeds up to 100 Gigabit per second, up from 10 and 40 Gigabit systems used previously.

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[30] *In re Rural Health Care Support Mechanism*, Order, 21 FCC Rcd 11111, 11113 ¶ 7 (2006) (quoting 47 U.S.C. § 254(h)(2)) ("*Pilot Program Order*").

[31] 47 U.S.C. § 254(a) (emphasis added).

The Commission has already determined that it may extend eligibility to telecommunications carriers and non-telecommunications carriers alike under section 254(h) of the Act. In the context of the Pilot Program, whose enabling statutory provision is section 254(h)(2)(A), the Commission "has exercised its authority under section 254(h)(2)(A) to establish discounts and funding mechanisms for advanced services provided by both telecommunications carriers and non-telecommunications carriers."[32] Accordingly, it is clear that not only may the Commission allow the funding of point-to-point connections, including dark and lit fiber services, but it does not matter who offers such connections. Recognizing such legal latitude will serve the public interest by increasing the ability of health care providers to choose among that many more offerings and vendors which will result in new and innovative services and reduced costs.

B. The Subsidy Percentage Should Be 50 Percent To 100 Percent Based On Need

The minimum subsidy under the HBS Program should be 50 percent and the FCC should allow for higher subsidies based on affordability and other criteria. As noted by the *Notice*, the National Broadband Plan recommended that the Commission base discount levels for the health care broadband access services on criteria that address such factors as lack of broadband access, lack of affordable broadband, price discrepancies for similar broadband services between health care providers, the health care provider's inability to afford broadband services, special status for health care providers in the highest Health Professional Shortage Areas ("HPSAs") of the country, and special status for public or safety net institutions.[33]

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[32] *Pilot Program Order*, 21 FCC Rcd at 11113 ¶ 7.

[33] *Notice*, 25 FCC Rcd at 9412 ¶ 104.

The Commission's 50 percent flat discount, however, takes none of these factors into consideration. Using only the HPSA neglects the differences in the health care needs of rural communities. For example, the areas in which RNHN members operate have very low HPSA scores for primary care, as shown in the table below. Yet the Nebraska Panhandle is an area of high need for broadband services.

Location	HPSA Primary Care Score	Location	HPSA Primary Care Score
Alliance	0	Oshkosh	14
Bridgeport	14	Scottsbluff	0
Chadron	0	Sidney	0
Gordon	13	Grant	0
Kimball	11		

Instead of using a single tiered discount system, RNHN proposes the a multi-tiered system of discounts based on a combination of HPSA, Medically Underserved Areas ("MUAs") and the rural classification of the Census Bureau.[34] These criteria measure different shortfalls in health care delivery. The MUA measures the percentage of the population below poverty, the percentage of the population that is elderly, the infant mortality rate, and the availability of primary care physicians whereas the HPSA measures only the shortage of primary care providers. A blended discount system, such as the one proposed below, would serve the goals of the HBS Program and also serves the Commission's goals of a mechanism that is easy to administer and which is specific and predictable.[35]

	Discount in %
Areas other than below	0%
Rural	50%
MUA	50%
Rural + HPSA	65%

[34] *See* Comments of the Intelenet Commission, Indiana, *In re Federal-State Joint Board on Universal Service*, WC Docket No. 02-60 (filed Jul. 1, 2002).

[35] *See Notice*, 25 FCC Rcd at 9413-14 ¶ 108; 47 U.S.C. § 254(b)(5).

Rural + MUA	75%
Rural + MUA + HPSA	90%
Rural + MUA + HPSA + inability to afford at other discount levels	100%

C. Capital Investment Costs And Other Non-recurring Charges Should Be Subject To Market Conditions

Reasonable and customary installation charges for broadband access under the HBS Program should be eligible for support because they are an integral component of providing broadband services. The Commission should not impose a requirement of a multi-year contract for non-recurring charges of more than $500,000 that must be prorated over a period of at least five years. The FCC should allow participants to seek and obtain what the market dictates. Such a condition could cripple the success and efficacy of the HBS Program because it essentially requires a vendor to finance the non-recurring costs of broadband access.

D. No Minimum Bandwidth Requirement Should Be Imposed

While it is understood that the Commission wants to promote high speed broadband adoption, the Commission should not impose a minimum speed requirement. In many rural locations, connections in excess of 4 Mbps are simply not available or are unaffordable.

The National Broadband Plan estimates that approximately 3,600 of the 307,000 small health care providers (offices with four or fewer physicians) do not have mass-market broadband available to them.[36] Of that 3,600, 70 percent are rural health care providers.[37] For larger health care providers, costs of high bandwidth broadband connections is the major barrier.[38] These

[36] *National Broadband Plan*, at 211.

[37] *Id.*

[38] Federal Communications Commission, Omnibus Broadband Initiative Technical Paper No. 5, *Health Care Broadband in America: Early Analysis and a Path Forward*, at 10 (rel. Aug. 27, 2010) ("OBI Technical Paper No. 5").

health care providers often purchase slower connections.[39] For example, over 80 percent of the participants in the Pilot Program indicate they are purchasing T1s.[40]

Additionally, in a recent filing in this proceeding, the Health Network Group Organized by Internet2 cited a survey conducted in 2009 in 28 rural counties in Florida.[41] The majority of the hospitals surveyed had only a T1 connection and 83.3 percent of the CIOs of hospitals surveyed ranked affordability of broadband as their greatest barrier to increasing their speed of connection.[42]

Given that the Commission does not currently have sufficient information regarding the comparative costs of higher bandwidth services that may be used by health care providers,[43] the Commission should not impose a minimum speed that rural health care providers can ill afford. Moreover, the Commission's basis for requiring a 4 Mbps minimum bandwidth—electronic health records, high quality video consultations, remote monitoring, and non-real time image downloads—have not yet been implemented by most rural providers, especially small rural providers. Giving rural health care providers the flexibility to purchase the connections they need now at a price they can afford will enhance innovation by freeing up needed cash so that such providers can adopt new medical care technologies.

E. Competitive Bidding Rules Should Not Apply To Eligible Services Transitioned From The Pilot Program And Should Be Flexible

RNHN agrees that Pilot Program participants should be allowed to transition, without going through a competitive bidding process, broadband services purchased under the Pilot

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39 *Id.*

40 *Id.*

41 *See, e.g.*, National Broadband Plan Public Notice #17, Comments of Health Network Group Organized by Internet2 (filed Dec. 2, 2009).

42 *Id.* at 3.

43 *Notice*, 25 FCC Rcd at 9413 ¶ 106.

Program to the HBS Program once the Pilot Program ends to subsidize the recurring costs for eligible services that were formerly funded under the Pilot Program. Participants should also be allowed to forego competitive bidding as long as it provides a basis for the vendor selection, including a justification for not utilizing competitive bidding and a cost/price analysis.[44]

V. ELIGIBLE HEALTH CARE PROVIDERS

A. Administrative Offices And Data Centers That Are A Integral Part Of The Provision Of Health Care Should Be Included In The Definition Of A Health Care Provider

A health care provider's off-site administrative offices and data centers are a vital and integral part of the provision of health care and the connections needed to access these locations should be eligible for support. Health care providers should not be penalized for deciding, for whatever reason, that administrative offices or data centers should reside in a different location than the location where patients are seen. Aggregating the servers and equipment needed to run these applications in central locations allows all participating hospitals and clinics in rural and under-served areas to share such applications and lower costs. If the connections between data centers and the individual sites are not funded, such cost savings would be impossible.

The requirement that the administrative offices or data centers be at least 51% owned or controlled by a health care provider should also not be adopted. Such a requirement neglects other forms of possession and use. Space for administrative offices and data centers can be leased or licensed. Locations that are leased or licensed are no less critical to the delivery of health care than a location that is at least 51% owned or controlled by a health care provider. Accordingly, a location should be included in the definition of a health care provider if the

[44] *See supra* note 27.

location is used primarily for performing services and functions that are vital and integral to the provision of health care by an eligible health care provider regardless of who owns it.

VI. ANNUAL CAPS AND PRIORITIZATION RULES

A. The Infrastructure Program Should Not Be Capped at $100 Million

The Commission should stay away from caps. As stated throughout these comments, caps and limitations prevent the Commission from fulfilling the goals of both programs by disqualifing applications that would otherwise demonstrate a significant need and by inhibiting potential applicants from submitting project proposals. Regardless, if the Commission insists on applying a cap, the Commission's own data shows that if any cap is placed on the amount of funds available for the health care support programs, more should be allocated to the Infrastructure Program than to the HBS Program. Indeed, the Commission states that demand under the existing USAC health care program, which is service oriented, has historically been less than $70 million whereas Pilot Program, which is infrastructure oriented, has an annual demand of $139 million.[45] Based on these historical usage numbers, there is no rational basis for capping the Infrastructure Program at $100 million.

B. Prioritization Rules For The HBS Program Should Be Based On Factors In Addition To HPSA

If necessary, HBS Program funding requests can be prioritized based on such factors as lack of broadband access, lack of affordable broadband, price discrepancies for similar broadband services between health care providers, the health care provider's inability to afford broadband services, the health care providers HPSA value, whether the health care provider is located in an area designated as an MUA, special status for public or safety net institutions, and

[45] *Notice*, 25 FCC Rcd at 9376 ¶ 9, 9421 ¶ 128.

geographic area covered. Additionally, no money should be set aside for innovative uses of broadband; however, RNHN would not oppose giving some form of preference to such projects.

VII. DATA GATHERING AND PERFORMANCE MEASURES

A. Meaningful Use Criteria

The proposal to make telecommunications funding contingent on meaningful use of electronic health records, if enacted, would dramatically reduce the funding available to rural providers since small and rural providers are the most likely not to achieve meaningful use. The Centers for Medicare & Medicaid Services' ("CMS") Final Healthcare Information Technology Incentive Rule estimates that 52% of critical access hospitals (the smallest rural hospitals) will not achieve meaningful use by 2016.[46] There is no rationale for withholding telecommunications support from such a large group of disadvantaged providers (who by the way will already be paying penalties to CMS for their inability to meet the meaningful use standard). This proposed provision would be counterproductive and must be rejected.

B. Other Performance Measures

RNHN agrees that performance goals are needed to measure the impact of universal service programs and demonstrate how participating health care entities are using the programs to take advantage of broadband capabilities for medical services or support. However, any reporting requirements should be reasonable and should not place additional burdens on health care providers. Performance measures should be reported annually.

Moreover, ongoing support should not be conditioned upon meeting performance standards. Using performance measures as a sword will lead to non-participation by the providers that need the help the most. Instead, non-performing participants should provide an

[46] Medicare and Medicaid Programs; Electronic Health Record Incentive Program, 75 Fed. Reg. 44314, 44557 (Jul. 28, 2010).

analysis of reasons for not meeting performance standards and provide steps for correcting problems. The Commission, along with other participants, can also assist providers by putting together best practices so that participants are enabled to achieve any performance goals.

VIII. CONCLUSION

RNHN respectfully urges the Commission to adopt the changes to the programs suggested in these comments. Without these changes, the new programs proposed will suffer from the same under utilization as the current Rural Health Care Support Mechanism. RNHN thanks the Commission for moving so quickly on implementing the recommendations in the National Broadband Plan, and it looks forward to working with the Commission further on implementing the Infrastructure and HBS Programs.

Respectfully submitted,

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